MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

COMPANION GUIDE FOR NCPDP PHARMACY ENCOUNTERS

TELECOMMUNICATION STANDARD VERSION 5.1 and BATCH STANDARD VERSION 1.1

September 23, 2003
(Updated July 12, 2004)

Michigan Department of Community Health

MDCH

MSA
MEDICAL SERVICES ADMINISTRATION

This document is intended as a companion to the **National Council for Prescription Drug Programs (NCPDP) Telecommunication Standard Version 5.1 and Batch Standard Version 1.1**, dated September 1999 and January 2000, respectively. Health Plans should also refer to the NCPDP Data Dictionary dated September 1999.

The clarifications described herein include:

- identifiers to use when national standard has not been adopted, and
- parameters in the implementation guide that provide options.

(The NCPDP implementation guide and specifications can be found at http://www.ncpdp.org/. Note that access to the implementation guides requires an NCPDP membership).

July 12, 2004 revisions to the Companion Guide for the NCPDP Encounter dated September 23, 2003 include:

1. Updated Comment fields for:

   - Batch Detail Record, Field 880-K5 – Transaction Reference Number (Page 2)
   - Insurance Segment, Field 301-C1 – Group ID (Page 3)
   - Claim Segment, Field 308-C8 – Other Coverage Code (Page 4)
   - Claim Segment, Field 429-DT – Unit Dose Indicator (Page 4)

The NCPDP Telecommunication Standard v. 5.1 is comprised of 14 transaction types. MDCH requires Health Plans to submit pharmacy encounter information using the Billing (B1), Reversal (B2), and Re-Billing (B3) transaction types only.

Batch Transaction Standard Version 1.1

Data Dictionary Page	Specification / Implementation Guide Pages	Segment	Field	Field Name	Comments
		Batch Transaction Header			**A Batch Transaction Header is required for every batch submitted.** **Note: This is a fixed width.**
94	4/5	Batch Transaction Header	880-K6	Transmission Type	Use “T” for Transaction.
86	4/5	Batch Transaction Header	880-K1	Sender ID	Use the 4-character billing agent ID assigned by MDCH (left justified space filled).
12	4/5	Batch Transaction Header	806-5C	Batch Number	Use a unique health plan created batch identification number. Must match the Batch Number in the Batch Trailer.
21	4/5	Batch Transaction Header	880-K2	Creation Date	Use CCYYMMDD format.
21	4/5	Batch Transaction Header	880-K3	Creation Time	Use HHMM format.
38	4/5	Batch Transaction Header	702	File Type	Use “T” for Test and “P” for Production.
95	4/5	Batch Transaction Header	102-A2	Version / Release Number	Use “11”
79	4/5	Batch Transaction Header	880-K7	Receiver ID	Use “D00111” for MDCH (left justified space filled).

	4/6	**Batch Detail Data Record**			**A Batch Detail Data Record is required for every NCPDP 5.1 record submitted within a batch.** **Note: This is fixed width.**
	4/6	Batch Detail Record	880-K5	Transaction Reference Number	Use a unique health plan assigned transaction reference number.

Telecommunication Standard Version 5.1

Data Dictionary Page	Implementation Guide Page	Segment	Field	Field Name	Comments
	5-1	**Transaction Header**			**This segment is required for B1, B2, and B3 transactions.** **Note: This is fixed width.**
13	5-1	Transaction Header	101-A1	BIN Number	Use “009737” for Michigan Medicaid.
95	5-1	Transaction Header	102-A2	Version/Release Number	Use “51”.
93	5-1	Transaction Header	103-A3	Transaction Code	Use “B1” for Billing, “B2” for Reversal, or “B3” for Rebilling.
72	5-1	Transaction Header	104-A4	Processor Control Number	Use “P008009737” for Michigan Medicaid.
93	5-1	Transaction Header	109-A9	Transaction Count	Use “1”, “2”, “3”, or “4” for B1, B2 and B3 transaction types unless billing is for a multi-ingredient prescription, then use “1”.
87	5-1	Transaction Header	202-B2	Service Provider ID Qualifier	Use “07” for NCPDP (NABP) ID Qualifier.
87	5-1	Transaction Header	201-B1	Service Provider ID	Use NCPDP (NABP) assigned ID Number.
88	5-1	Transaction Header	110-AK	Software Vendor / Certification ID	Use 4-character billing agent ID assigned by MDCH. Should match number reported in 880-K1, Sender ID.
	5-1	**Patient**			**MDCH does not require this segment for B1, B2, and B3 transactions.**

Data Dictionary Page	Implementation Guide Page	Segment	Field	Field Name	Comments
	5-2	**Insurance**			**MDCH requires this segment for B1 and B3 transactions. It is optional for B2 transactions.**
13	5-2	Insurance	302-C2	Cardholder ID	Use the patient's 8-digit beneficiary ID number assigned by MDCH. For MIChild enrollees use the 8-digit Client Identification Number (CIN) assigned by the enrollment broker.
13	5-2	Insurance	312-CC	Cardholder First Name	Use the first name of the subscriber as it appears on the files of the capitated plan or other payer.
13	5-2	Insurance	313-CD	Cardholder Last Name	Use the last name of the subscriber as it appears on the files of the capitated plan or other payer.
63	5-2	Insurance	524-FO	Plan ID	Use "D00111" for MDCH.
41	5-2	Insurance	301-C1	Group ID	Use "MIMEDICAID" for Michigan Medicaid beneficiaries. Use "MICHILD" for children enrolled in the MICHILD program. Use "ABWI" for those enrolled in the Adult Benefit Waiver Phase I Program.
	5-3	**Claim**			**MDCH requires this segment for B1, B2 and B3 transactions.**
66	5-3	Claim	455-EM	Prescription / Service Reference Number Qualifier	Use "1" for Rx Billing.
66	5-3	Claim	402-D2	Prescription / Service Reference Number	Use the number assigned by the pharmacy for the dispensed drug/product.
74	5-3	Claim	436-E1	Product / Service ID Qualifier	Use "03" for National Drug Code (NDC).
74	5-3	Claim	407-D7	Product / Service ID	Use the 11-character NDC unless billing compounds, then use "0".
76	5-3	Claim	442-E7	Quantity Dispensed	Use metric decimal units.
38	5-3	Claim	403-D3	Fill Number	Use "0" for Original Dispensing. Use "1, 2, 3,…99" for Refill Number.
24	5-3	Claim	405-D5	Days Supply	MDCH requires this element.
16	5-3	Claim	406-D6	Compound Code	Use "0" for Not Specified, "1" for Not a Compound, or "2" for Compound.

Data Dictionary Page	Implementation Guide Page	Segment	Field	Field Name	Comments
27	5-3	Claim	408-D8	Dispense as Written	Use the following values: "0" – No Product Selection Indicated "1" – Substitution Not Allowed By Prescriber "2" – Substitution Allowed – Patient Requested Product Dispensed "3" – Substitution Allowed – Pharmacist Selected Product Dispensed "4" – Substitution Allowed – Generic Drug Not in Stock "5" – Substitution Allowed – Brand Drug Dispensed As Generic "6" – Override "7" – Substitution Not Allowed – Brand Drug Mandated By Law "8" – Substitution Allowed – Generic Drug Not Available in Marketplace "9" - Other
23	5-3	Claim	414-DE	Date Prescription Written	MDCH requires this element.
50	5-3	Claim	415-DF	Number of Refills Authorized	MDCH requires this element.
89	5-3	Claim	420-DK	Submission Clarification Code	MDCH requires this element when clarification is needed for specific provider-level override conditions. Refer to the NCPDP Data Dictionary for override conditions and standard values.
76	5-3	Claim	460-ET	Quantity Prescribed	MDCH requires this element.
53	5-3	Claim	308-C8	Other Coverage Code	Use "0" for Not Specified, "1" for No Other Coverage, "2" for Other Coverage Exists – Payment Collected, "3" for Other Coverage Exists – Claim Not Covered, "4" for Other Coverage Exists – Payment Not Collected, "5" for Managed Care Plan Denial, "6" for Other Coverage Denied – Not a Participating Provider, "7" for Other Coverage Exists – Not in Effect DOS or "8" for Claim is Billing for Co-pay.
94	5-3	Claim	429-DT	Unit Dose Indicator	MDCH requires this element when the pharmacy has repackaged a non-unit dose product. Use "3" for Pharmacy Unit Dose.

Data Dictionary Page	Implementation Guide Page	Segment	Field	Field Name	Comments
94	5-3	Claim	600-28	Unit of Measure	Use “EA” for Each, “GM” for Grams, or “ML” for Milliliters.
43	5-3	Claim	418-DI	Level of Service	Use “0” for Not Specified, “1” for Patient Consultation, “2” for Home Delivery, “3” for Emergency, “4” for 24-Hour Service, “5” for Patient Consultation Regarding Generic Product Selection, or “6” for In Home Service.
71	5-3	Claim	461-EU	Prior Authorization Type Code	MDCH requires this element when needed to identify designated prior authorization or benefit/plan exemptions. Refer to the NCPDP Data Dictionary for standard prior authorization or benefit/plan exemption values.
	5-3	**Pharmacy Provider**			**MDCH does not require this segment for B1 and B3 transactions. It is not used for B2.**
	5-4	**Prescriber**			**MDCH requires this segment for B1 and B3 transactions. It is not used for B2 transactions.**
65	5-4	Prescriber	466-EZ	Prescriber ID Qualifier	Use “12” for Drug Enforcement Administration (DEA) Number
65	5-4	Prescriber	411-DB	Prescriber ID	Use provider’s DEA Number.
	5-4	**COB**			**This segment is required for B1 and B3 transactions. It is not used for B2 transactions. This segment can only be reported once per claim segment. Repeat the COB loop once for the capitated health plan and once for each other payer. MDCH will accept a maximum of 3 other payers per encounter.**
19	5-4	COB	337-4C	Coordination of Benefits / Other Payments Count	MDCH requires this element.

Data Dictionary Page	Implementation Guide Page	Segment	Field	Field Name	Comments
54	5-4	COB	338-5C	Other Payer Coverage Type	Use “01” for Primary, “02” for Secondary, or “03” for Tertiary. If the patient has no other insurance, report the capitated health plan coverage as “01”. If the patient has other insurance coverage, report that coverage as “01” or “02”, as appropriate, and the capitated health plan coverage with “02” or “03”, as appropriate.
55	5-4	COB	339-6C	Other Payer ID Qualifier	Use “99” for Other Payer ID Qualifier.
54	5-4	COB	340-7C	Other Payer ID	For the capitated health plan, use the 9-digit Payer ID assigned by MDCH, for example, “171234567. For other payers, use the carrier code assigned by MDCH (see MDCH website for listing of carrier codes). For example, if BCBSM Traditional were the Other Payer, the value (carrier code) reported in this field would be “00029005. For Medicare Part A (United Government Services) use “00452”. For Medicare Part B (Wisconsin Physician Services) use “00953”.
54	5-4	COB	443-E8	Other Payer Date	Use the Other Payer paid or denied date.
53	5-4	COB	341-HB	Other Payer Amount Paid Count	MDCH requires this element. Use “1” or “2” according to the number of other payer amounts paid.
53	5-4	COB	342-HC	Other Payer Amount Paid Qualifier	For the capitated health plan use “99” Other **and** “04” Administrative. For other payers use “08” Sum of All Reimbursement.
53	5-4	COB	431-DV	Other Payer Amount Paid	For the capitated health plan report the amount paid to the pharmacy for the prescription or product for qualifier “99” **and** report the dispensing fee for the qualifier “04”. For other payers report the amount of any payment known by the pharmacy from other sources for qualifier “08”.

Data Dictionary Page	Implementation Guide Page	Segment	Field	Field Name	Comments
	5-4	**Worker's Compensation**			**MDCH does not require this segment for B1 or B3 transactions. It is not used for B2.**
	5-5	**DUR/PPS**			**MDCH requires this segment to be sent for B1 and B3 transactions if there is DUR information. It is optional for B2.**
31	5-5	DUR/PPS	473-7E	DUR/PPS Code Counter	MDCH requires this element. MDCH can accommodate a maximum of "9".
77	5-5	DUR/PPS	439-E4	Reason for Service Code	Use the appropriate values outlined in the NCPDP Data Dictionary to identify the type of utilization conflict detected or the reason for the pharmacist's professional services.
75	5-5	DUR/PPS	440-E5	Professional Service Code	Use the appropriate code values outlined in the NCPDP Data Dictionary to identify the pharmacist intervention when a conflict code has been identified or service rendered..
84	5-5	DUR/PPS	441-E6	Result of Service Code	Use the appropriate code values outlined in the NCPDP Data Dictionary to identify the action taken by the pharmacist in response to a conflict or the result of a pharmacist's professional service.
	5-5	**Pricing**			**MDCH requires this segment for B1 and B3 transactions. It is optional for B2 transactions.**
43	5-5	Pricing	409-D9	Ingredient Cost Submitted	Use the ingredient cost submitted to the capitated health plan by the pharmacy in overpunch format.
29	5-5	Pricing	412-DC	Dispensing Fee Submitted	Use the dispensing fee submitted to the capitated health plan by the pharmacy in overpunch format.
75	5-5	Pricing	477-BE	Professional Service Fee Submitted	Use the professional service fee submitted to the capitated health plan by the pharmacy in overpunch format.
58	5-5	Pricing	433-DX	Patient Paid Amount Submitted	Use the patient paid amount submitted to the capitated health plan by the pharmacy in overpunch format.

Data Dictionary Page	Implementation Guide Page	Segment	Field	Field Name	Comments
42	5-5	Pricing	438-E3	Incentive Amount Submitted	Use the incentive amount submitted to the capitated health plan by the pharmacy in overpunch format.
94	5-5	Pricing	426-DQ	Usual and Customary Charge	Use the pharmacy's usual and customary charge as submitted to the health plan.
40	5-5	Pricing	430-DU	Gross Amount Due	Use the gross amount due submitted to the capitated health plan by the pharmacy in overpunch format.
	5-5	**Coupon**			**MDCH does not require this segment for B1 or B3 transactions. It is not used for B2.**
	5-6	**Compound**			**MDCH requires this segment for B1 and B3 transactions when a compound is being reported. It is not used for B2 transactions.**
16	5-6	Compound	450-EF	Compound Dosage Form Description Code	Use the appropriate code values outlined in the NCPDP Data Dictionary to identify the dosage form of the complete compound mixture.
16	5-6	Compound	451-EG	Compound Dispensing Unit Form Indicator	Use "1" for Each, "2" for Grams, or "3" for Milliliters.
18	5-6	Compound	452-EH	Compound Route of Administration	Use the appropriate code value outlined in the NCPDP Data Dictionary to identify the route of administration of the complete compound mixture.
17	5-6	Compound	447-EC	Compound Ingredient Component Count	Use the total count of the compound product IDs (active and inactive) in the compound mixture submitted.
17	5-6	Compound	488-RE	Compound Product ID Qualifier	For each compound product, use "03" for NDC.
17	5-6	Compound	489-TE	Compound Product ID	For each compound product, use the 11-character NDC.
17	5-6	Compound	448-ED	Compound Ingredient Quantity	For each compound product, use amount of the product included in the compound mixture in metric decimal units.

Data Dictionary Page	Implementation Guide Page	Segment	Field	Field Name	Comments
17	5-6	Compound	449-EE	Compound Ingredient Drug Cost	For each compound product, use ingredient cost for product included in the compound mixture.
17	5-6	Compound	490-UE	Compound Ingredient Basis of Cost Determination	For each compound product, use the appropriate code value outlined in NCPDP Data Dictionary to identify the method by which the drug cost of an ingredient used in a compound was calculated.
	5-6	**Prior Authorization**			**MDCH does not require this segment for B1 and B3 transactions. It is not used for B2.**
	5-6	**Clinical**			**MDCH requires this segment to be sent for B1 and B3 transactions when diagnosis is required for designated drug coverage or otherwise available. It is not used for B2 transactions.**
25	5-6	Clinical	492-WE	Diagnosis Code Qualifier	Use “01” for International Classification of Diseases (ICD-9).
25	5-6	Clinical	424-DO	Diagnosis Code	Use ICD-9 code including decimal points.

Batch Transaction Standard Version 1.1

Data Dictionary Page	Specification / Implementation Guide Page	Segment	Field	Field Name	Comments
		Batch Trailer			**A Batch Trailer is required for all transaction types.**
12	4/6	Batch Trailer	806-5C	Batch Number	Use a unique health plan created batch identification number. Must match the Batch Number in the Batch Header.
80	4/6	Batch Trailer	751	Record Count	Include the total number of records in the batch, including the header and trailer records.